as reported on form HCFA 2082 for the base year.

Q=The market basket index for SNF and ICF (NF effective October 1, 1990) services for the waiver year involved, defined as the total SNF Input Price Index used in the Medicare program, identified as the third quarter data available from HCFA's Office of National Cost Estimates in August preceding the start of the fiscal year.

R=The SNF Input Price Index for the base year.

S=The number of residents in the State in the waiver year involved who have reached age 65, defined as the number of aged Medicare beneficiaries in the State, equal to the Mid-Period Enrollment in HI or SMI in that State on July 1 preceding the start of the fiscal year.

T=The number of aged Medicare beneficiaries in the State who are enrolled in either the HI or SMI programs in the base year, as defined in S, above.

U=The number of years beginning after the base year and ending on the last day of the waiver year involved.

V=The aggregate amount of the State's medical assistance under title XIX in the base year for home and community-based services for individuals who have reached age 65, defined as the total medical assistance payments (Federal and State) reported on line 6 of form HCFA 64 (as adjusted) for home health, personal care, and home and community-based services waivers, which provide services as an alternative to care in a SNF or ICF (NF effective October 1, 1990), increased by an estimate (acceptable to HCFA) of expenditures for private duty nursing services, multiplied by the ratio of expenditures for home health services for the aged to total expenditures for home health services, as reported on form HCFA 2082, for the base year.

W=The market basket index for home and community-based services for the waiver year involved, defined as the Home Agency Input Price Index, used in the Medicare program identified as the third quarter data available from HCFA's Office of National Cost Estimates in August preceding the start of the fiscal year.

X=The Home Health Agency Input Price Index for the base year.

Y=The greater of—
(U×.07), or (Q/R)-1+(S/T)-1+(U×.02).

Z=The greater of—
(U×.07), or (W/X)-1+(S/T)-1++(U×.02).

(d) *Amendment of the APEL.* The State may request amendment of its APEL to reflect an increase in the aggregate amount of medical assistance for NF services and for services included in the calculation of the APEL as required by paragraph (c) of this section when the increase is directly attributable to legislation enacted on or after December 22, 1987, which amends title XIX of the Act. Costs attributable to laws enacted before December 22, 1987 will not be considered. Because the APEL for each year of the waiver is computed separately from the APEL for any other waiver year, a separate amendment must be submitted for each year in which the State chooses to raise its APEL. Documentation specific to the waiver year involved must be submitted to HCFA.

§ 441.355 Duration, extension, and amendment of a waiver.

(a) *Effective dates and extension periods.* (1) The effective date for a waiver of Medicaid requirements to furnish home and community-based services to individuals age 65 or older under this subpart is established by HCFA prospectively on the first day of the FFY following the date on which the waiver is approved.

(2) The initial waiver is approved for a 3-year period from the effective date. Subsequent renewals are approved for 5-year periods.

(3) If the agency requests it, the waiver may be extended for an additional 5-year period if HCFA's review of the prior period shows that the assurances required by § 441.352 were met.

(4) The agency may request that waiver modifications be made effective retroactive to the first day of the waiver year in which the amendment is submitted, unless the amendment involves substantive change. Substantive changes may include, but are not limited to, addition of services under the waiver, a change in the qualifications of service providers, or a change in the eligible population.

(5) A request for an amendment that involves a substantive change is given a prospective effective date, but this date need not coincide with the start of the next FFY.

(b) *Extension or new waiver request.* HCFA determines whether a request for extension of an existing waiver is actually an extension request, or a request for a new waiver. Generally, if a State's extension request proposes a

substantive change in services furnished, eligible population, service area, statutory sections waived, or qualifications of service providers, HCFA considers it a new waiver request.

(c) *Reconsideration of denial.* A determination of HCFA to deny a request for a waiver (or for extension of a waiver) under this subpart may be reconsidered in accordance with § 441.357.

(d) *Existing waiver effectiveness after denial.* If HCFA denies a request for an extension of an existing waiver under this subpart:

(1) The existing waiver remains in effect for a period of not less than 90 days after the date on which HCFA denies the request, or, if the State seeks reconsideration in accordance with § 441.357, the date on which a final determination is made with respect to that review.

(2) HCFA calculates an APEL for the period for which the waiver remains in effect, and this calculation is used to pro-rate the limit according to the number of days to which it applies.

§ 441.356 Waiver termination.

(a) *Termination by the State.* If a State chooses to terminate its waiver before an approved program is due to expire, the following conditions apply:

(1) The State must notify HCFA in writing at least 30 days before terminating services to recipients.

(2) The State must notify recipients of services under the waiver at least 30 days before terminating services in accordance with § 431.210 of this chapter.

(3) HCFA continues to apply the APEL described in § 441.354 through the end of the waiver year, but this limit is not applied in subsequent years.

(4) The State may not decrease the services available under the approved State plan to individuals age 65 or older by an amount that violates the comparability of service requirements set forth in § 440.240 of this chapter.

(b) *Termination by HCFA.* (1) If HCFA finds, during an approved waiver period, that an agency is not meeting one or more of the requirements for a waiver contained in this subpart, HCFA notifies the agency in writing of its findings and grants an opportunity for a hearing in accordance with § 441.357. If HCFA determines that the agency is not in compliance with this subpart after the notice and any hearing, HCFA may terminate the waiver.

(2) If HCFA terminates the waiver, the following conditions apply:

(i) The State must notify recipients of services under the waiver at least 30 days before terminating services in accordance with § 431.210 of this chapter.

(ii) HCFA continues to apply the APEL in § 441.354 of this subpart, but the limit is prorated according to the number of days in the fiscal year during which waiver services were offered. The limit expires concurrently with the termination of home and community-based services under the waiver.

§ 441.357 Hearing procedures for waiver denials.

The procedures specified in § 430.18 of this subchapter apply to State requests for hearings on denials, renewals, or amendments of waivers for home and community-based services for individuals age 65 or older.

§ 441.360 Limits on Federal financial participation (FFP).

FFP for home and community-based services listed in § 440.181 of this subchapter is not available in expenditures for the following:

(a) Services furnished in a facility subject to the health and welfare requirements described in § 441.352(a) during any period in which the facility is found not to be in compliance with the applicable State requirements described in that section.

(b) The cost of room and board except when furnished as part of respite care services in a facility, approved by the State, that is not a private residence. For purposes of this subpart, ''board'' means three meals a day or any other full nutritional regimen. ''Board'' does not include meals, which do not comprise a full nutritional regimen, furnished as part of adult day health services.

(c) The portion of the cost of room and board attributed to unrelated, live-in personal caregivers when the waiver recipient lives in the caregiver's home or a residence owned or leased by the provider of the Medicaid services (the caregiver).